♦♦♦ Standardized Consumer STR Interview and Registration Form **♦**♦♦

	Name, M.I., and First Name of Consumer	MM DD YYYY	C. LME		•
F. Na	STR Interview items (1 - 48) are required to be conception of care (minimum of no billable services of STR is designed as a brief inquiry, not an in-depth STR is intended to identify the nature of a present STR is to be conducted as efficiently and effective Upon Determination of a Triage Severity of Need, Registration items (1 & 49 - 55) are designated by This form is required to be submitted to the LME of transmittal is required to conform to HIPAA standard.	G. Medicaid Provider Enrollment I gistration Form is required to be a impleted by all facilities performing swithin prior 60 days). STR is required assessment, to determine need and ting mh/dd/sas problem, recommencely as possible, within the Screening prompt consumer referral to a proving "®", and are required to be completed within five business days of Screening ands for electronic health care transactions.	No.® H. IPRS A completed by a STR. STR is ap and to be conducted to facilitate and a Triage Sever method and tire ider of choice of eted for all new and or service ini- actions, and cor	Attendall LN oproperted beccess erity of the average of the or printing of the or printin	And the service of th
 1. 2. 3. 4. 5. 8. 	Date of Consumer Screening: Consumer Co. of Residence: (Enter county name or county code Is consumer currently enrolled in Medica Screening Referral Source of consumer: (Enter referral source name or source		or ☐ ☐	15.	Does Screening indicate consumer is in need of Detox due
11. 12.	12b) 2 nd : (✓ One, if applic.) ☐ AMH ☐ 0	S): (Attachment should be included bility: (Not Target Population detected ASA CMH	ed) ermination) CSA CSA CSA		Emergent:

Note: Information is fully protected as a consumer health record under HIPAA, 42 CFR, Part 2, and G.S. 122C and contains individually identifiable health information. Disclosure of HIPAA protected information between providers and other covered entities may require consumer authorization. For consumers with substance abuse problems, written consent is required under 42 CFR, Part 2, for disclosure of confidential consumer information, unless such disclosure is permitted as an exception to the General Confidentiality Rule, including a medical emergency that poses an immediate threat to health and requires immediate medical intervention. Redisclosure of SA consumer information is prohibited under 42 CFR, Part 2. Page 1 of 4: DMHDDSAS Approved Eff.: 08/10/06

♦♦♦ Standardized Consumer STR Interview and Registration Form **♦**♦♦

Last Name, M.I., and First Name of Consumer MM DD YYYY A. Consumer Name ® B. Consumer DOB ® C. LME			Complete as indicated by LME, or may be assigned by LME upon receipt. D. LME Facility Code ® E. LME Consumer Record No. ®
19.	If Item No. 17 above is checked for "Community Resources", skip to Item 26. What initial service(s) does Screener recommend for consumer? (✓ All that apply) □ Diagnostic Assessment □ Community Support □ Targeted Case Mgt. □ Other □ Clin. Intake/Eval. (90801) □ Beh. HIth. Assess. (H0001) □ Men. HIth. Assess. (H0031) Has provider appointment date and time (or crisis service) been offered to consumer? □ Yes □ No □ N/A If "Yes", complete Item 20. If "No" or "N/A", skip to 26. Has provider appointment (or crisis service) that was offered been accepted by the consumer?	Has the other suppo	der:
21.	☐ Yes ☐ No If "Yes", complete Items 21 – 22. If "No", skip to Item 26. Provider Agency Referred to and Location:	38. Maili	ing Address/City/State/Zip Code:
22.	Phone No. of Provider Referred to: Complete Item 23 only for Enhanced Benefits Service or Crisis Service, based on		sumer's Legal Guardian (if applicable):
23.	Appointment Date & Time Scheduled: (or Crisis Service Initiated) Appointment Date & Time Scheduled: MM DD YYYY HH MM	41. Eme	ergency Contact Name & Relationship:
24.	How was Provider Chosen? (✓ One only) ☐ Consumer Choice ☐ Family/Legal Guardian Choice ☐ Screener Decision ☐ Other Person Decision (Identify):	44. <u>Type</u>	sumer Unique Identifier: e of Agency Hosting STR: (✓ All that apply) ME Operated or Contracted STR ☐ Enhanced Benefits Service Enrolled Provider
25.	Why was Provider Chosen? (✓ All that apply) ☐ Consumer Coverage Benefits ☐ Crisis or Urgent Access ☐ 1 st Available ☐ Hours ☐ Location ☐ Cultural Reasons ☐ Reputation/Recommended by Others ☐ Provider Specialty	□ LN 45 . □ □	ME Contracted Service Provider
26.	☐ Other Reason (Describe) Accommodation of Special Consumer Needs: (✓ All that apply) ☐ Not Applic. ☐ Wheelchair/Mobility Needs ☐ Interpreter (Sign Language) ☐ Deaf/Hearing Impaired ☐ Intellectual Disability ☐ Childcare ☐ Visually Impaired ☐ Physical Disability	 47. □□	Staff Qualifications: □ QP in MH □ QP in SA □ QP in DD □ YYYY □ □ □ □
	☐ Frail Senior ☐ Other (Describe)	SIR	Staff Area Code, Phone No., & Extension Date Form Submitted to LM
	Primary Care Medical Provider: (List name & practice of licensed MD, PA, or NP) What special arrangements were made for services access? (All that apply)	49. ® Da	CONSUMER REGISTRATION FOR ENHANCED BENEFITS PROVIDERS te of Consumer Service Initiation: □□/□□/□□□□□
	□ None □ Transportation □ Site Accessibility □ Other (Describe): Ethnicity: (✓ One) □ Hispanic, Mexican American □ Hispanic, Puerto Rican □ Hispanic, Cuban □ Hispanic, Other □ Not Hispanic Origin □ Unknown	Com _i 50. ® <u>Co</u>	plete ID Nos. (as applicable & available) nsumer Social Security Number: eeded for cross referencing with CNDS)
	Race: (✓ One) □ Black/Afric. Amer. □ White/Anglo/Cauc. □ Amer. Ind./Native American □ Alaska Native □ Asian □ Native Hawaiian □ Pacific Islander □ Unknown □ Other (Describe):	51. ® <u>Co</u> 52. ® 🔲 [nsumer Medicaid Number:
	Is consumer proficient in English? (✓ One) Yes No Primary Language: (✓ One) English Sign Language French Spanish Other None Unknown	54. ® 🗌 [Mail Address of Registration Provider Staff MM DD YYYY 55. ®

Note: Information is fully protected as a consumer health record under HIPAA, 42 CFR, Part 2, and G.S. 122C and contains individually identifiable health information. Disclosure of HIPAA protected information between providers and other covered entities may require consumer authorization. For consumers with substance abuse problems, written consent is required under 42 CFR, Part 2, for disclosure of confidential consumer information, unless such disclosure is permitted as an exception to the General Confidentiality Rule, including a medical emergency that poses an immediate threat to health and requires immediate medical intervention. Redisclosure of SA consumer information is prohibited under 42 CFR, Part 2. Page 2 of 4: DMHDDSAS Approved Eff.: 08/10/06

INSTRUCTIONS FOR STANDARDIZED CONSUMER STR INTERVIEW AND REGISTRATION FORM

- A. <u>Consumer Name:</u> Enter consumer's Last Name, Middle Initial, and First Name: *up to 15 characters*.
- B. <u>Consumer DOB:</u> Enter consumer's date of birth, by month, day, and year: 8 characters.
- C. <u>LME Name:</u> Enter name of consumer's Local Management Entity (LME): *up to 12 characters*.
- D. <u>LME Facility Code</u>: LME Facility Code may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: 5 characters.
- E. <u>LME Consumer Record No:</u> LME Consumer Record Number may be completed as indicated by LME, or may be assigned by LME upon receipt of Form: 10 characters.
- F. Name of Provider Agency or LME Completing Form; Enter name of provider agency or LME completing this Form: up to 15 characters.
- G. Medicaid Provider Enrollment No: Enter provider's Medicaid Provider Enrollment No., if applicable: 8 characters.
- H. <u>IPRS Attending Provider No.</u> Enter provider's IPRS Attending Provider No., if applicable: 8 characters.
- I. <u>National Provider Identifier (NPI) No:</u> Enter provider's National Provider Indentifier (NPI) No., if applicable: 10 *characters*.
- J. Provider Consumer Record No: Enter provider's Consumer Record No: 10 characters.
- Entry Type: Indicate whether the Form is being completed for a STR Interview Only, a Consumer Registration Only, or both a STR Interview and Consumer Registration: (One).
- Consumer Screening Date: Enter month, day, and year which represents the date that this consumer was screened for the current episode of care: 8 characters.
- Consumer Co. of Residence: Enter a county name (up to 12 characters) or valid county code (3 characters) for the state of North Carolina as listed in the CDW Data Dictionary.
- 4. Consumer Enrollment in Medicaid: Indicate whether the consumer is currently enrolled in Medicaid: (One).
- Screening Referral Source: Enter the appropriate Screening Referral Source code from the below for principal source that referred the consumer to the facility for the screening: 2 characters.
 - 01= Self or no referral
 - 10= Family or friends
 - 21= Other outpatient and residential non-state facility
 - 22= State facility
 - 23= Psychiatric service, General hospital
 - 32= Non-residential treatment/habilitation program
 - 41= Private physician
 - 44= Nursing home board and care
 - 46= Veteran's Administration
 - 48= Other health care

- 60= Community agency
- 71= Court, corrections, prisons
- 80= Schools 99= Othe
- 6. Time Screening Began: Enter the time, in hours and minutes, using a 24 hour time clock format to indicate when the STR Interview began: 4 characters.
- 7. <u>Time Screening Ended</u>: Enter the time, in hours and minutes, using a 24 hour time clock format to indicate when the STR Interview ended: *4 characters*.
- 8. <u>Screening Method:</u> Indicate whether the Screening Method was in-person face to face or by telephone: (\(\nabla \) One).
- Name of Person Initiating Request for Services: Enter the name of the individual who is initiating this request for services, and the individual's relationship to the consumer. This individual may be the consumer who is making a direct request on their own behalf.
- Phone Number of Person Initiating Request for Services: Enter the phone number of the individual who is initiating this request for services: 8 characters.
- 11. <u>Brief Description of Presenting Problem:</u> Provide a brief description of the consumer's presenting problem. *(Complete narrative).*
- 12. Presenting Age/Disability Problem(s) of Consumer: Indicate the presenting age/disability problem(s) in order of importance. This item is not a determination of Target Population eligibility. (✓ One box for first row for primary problem, and up to one box each for the second and third rows for secondary and tertiary problems).
- Current Risk to Consumer Safety: Indicate the current risk to the consumer's safety using the five point Scale provided: (✓ One box for each of three dimensions).
- Need for <u>Detox Services</u>: Indicate whether the consumer is in need of detox services due to risk for acute alcohol or drug withdrawal symptoms. If "yes", check all symptoms that apply.
- 15. <u>Current Risk of Potential Harm to Self or Others:</u> Indicate the current risk of potential harm to self or others using the five point Scale and the criteria provided: (One box for each of two dimensions).
- Triage Severity of Need Determination: Indicate the consumer's Triage Severity of Need Determination of Emergent, Urgent, Routine, or Non-Threshold Clinical Need: (Y One)
- Consumer Referral after Triage: Indicate where the consumer is referred for response after Triage: (✓ One).
 If Item No. 17 above is checked for "Community Resources", skip to Item 26.
- 18. <u>Initial Services(s) Recommended for Consumer:</u> Indicate what initial services are recommended by the Screener for the consumer. (All that Apply).
- 19. Offer of Provider Appointment to Consumer: Indicate whether an appointment date and time (or crisis service) has been offered to the consumer by the provider: (✓ One). If "Yes", complete Item 20. If "No" or "N/A", skip to 26.

INSTRUCTIONS FOR STANDARDIZED CONSUMER STR INTERVIEW AND REGISTRATION FORM

- 20. Acceptance of Provider Appointment by Consumer: Indicate whether the appointment date and time that has been offered to the consumer by the provider has been accepted by the consumer: (✓ One). If "Yes", complete Items 21 22. If "No", skip to Item 26.
- 21. <u>Provider Agency Referred to and Location:</u> Identify the provider agency and location that the consumer has been referred to.
- 22. Phone Number of Provider Referred to: Identify the phone number of the provider that the consumer has been referred to.

 Complete Item 23 only for Enhanced Benefits Service or Crisis Service, based on appointment or actual receipt of a Crisis Service. (Enter date and time)
- 23. Appointment Date and Time Scheduled: Enter the provider scheduled appointment date and time in a 24 hour format, or the date and time that the crisis service was initiated: 8 characters followed by 4 characters.
- 24. How Provider was Chosen: Indicate how the provider was selected. (✓ One Only).
- 25. Why Provider Was Chosen: Indicate how the provider was selected. (✓ All that apply).
- 26. Accommodation of Special Consumer Needs: Indicate any accommodation made to meet special needs of the consumer. (All that apply).
- 27. <u>Consumer's Primary Medical Provider:</u> Enter the name of the consumer's primary health care provider physician, physician's assistant, or nurse practitioner.
- 28. Special Arrangements for Services Access: Indicate any special arrangements made for services access. (All that apply).
- 29. Ethnicity: Indicate the consumer's Hispanic origin: (One).
- 30. Race: Indicate the consumer's primary racial affiliation: (✓ One).
- 31. English Proficiency: Indicate whether English is spoken and understood by the consumer at a relatively high level of proficiency, e.g. no interpreter is required: (✓ One).
- 32. Primary Language: Indicate the language spoken and/or understood by the consumer: (one).
- 33. Gender: Indicate the consumer's sex: (✓ One).
- 34. Veteran Status: Indicate whether the individual has served on active duty in the armed forces of the U.S., including the Coast Guard: (One).
- 35. National Guard or Military Reserve: Indicate whether the consumer or an immediate family member (parent, grandparent, sibling, spouse, partner, child, or other significant person in the family constellation) has served in the National Guard or Military Reserve in support of Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF): (One).
- 36. <u>Consumer's Street Address/City/State:</u> Enter this information for consumer as appropriate and available.
- Consumer's Phone Number: Enter this information for consumer as appropriate and available.

- 38. Consumers' Mailing Address/City/State/Zip Code: Enter this information for consumer as appropriate and available.
- 39. <u>Consumer's Legal Guardian (if applicable):</u> Enter this information for consumer as appropriate and available.
- 40. Phone No. of Consumer's Legal Guardian (if applicable): Enter this information for consumer as appropriate and available.
- 41. Emergency Contact Name and Relationship for Consumer: Enter this information for consumer as appropriate and available.
- 42. <u>Phone Number of Emergency Contact for Consumer:</u> Enter this information for consumer as appropriate and available.
- 43. Consumer Unique Identifier: Enter consumer number: 10 or 11 characters. The unique identifier consists of the first three characters of last name, 1st character of first name, 6 character birth date, and an identifier if more than one LME consumer has the same unique identifier number.
- 44. Type of Agency Hosting STR: Indicate type of agency hosting STR. (✓ All that apply).
- 45. Name of Qualified Professional (QP) conducted STR Interview: List first and last name of the QP staff who conducted the STR Interview.
- 46. STR Staff Qualifications: Indicate the QP qualifications by disability group. (

 All that apply).
- 47. STR Staff Area Code, Phone No., & Extension: Enter the area code, phone number, and extension of the provider staff who conducted the STR Interview.
- 48. <u>Date Form Submitted to LME</u>: Enter the date by month, day, and year that this form was submitted to the LME.
 - CONSUMER REGISTRATION FOR ENHANCED BENEFITS PROVIDERS
- 49. ® <u>Date of Consumer Service Initiation</u>: Enter the date by month, day, and year that services to the consumer were initiated: 8 characters.
- 50. ® Consumer Social Security Number: Enter consumer number: 9 characters. This number is needed for cross-referencing with the Department's Common Name Database Services (CNDS). A consumer SSN will not always be available to a provider when completing this Form.
- 51. ® Consumer Medicaid Number: Enter consumer number: 10 characters.
- 52. ® First and Last Name of Provider Staff submitting this Form to LME: Enter first and last name of staff submitting this form to LME: up to 24 characters.
- 53. ® E-Mail of Provider Staff submitting this Form to LME: Enter e-mail address of staff submitting this form to LME: up to 24 characters.
- 54. ® Area Code and Phone No.: Enter area code and phone number of staff submitting this form to the LME: 10 characters.
- 55. ® <u>Date Form Submitted to LME:</u> Enter date by month, day, and year that this form was submitted to the LME by the provider: *8 characters*.